STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 00 B. WING	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00093490 and IN00094635. Complaint IN00093490- Substantiated, Federal/State deficiencies related to the allegations are cited at F225, F226, and F323. Complaint IN00094635- Substantiated, Federal/State deficiency related to the allegations is cited at F514. Survey dates: August 10 and 11, 2011 Facility number: 000125 Provider number: 155220 AIM number: 100266740 Survey team: Janelyn Kulik, RN, TC Regina Sanders, RN Kelly Sizemore, RN Census bed type: SNF/NF: 136 Residential: 45 Total: 181 Census payor type: Medicare: 24 Medicaid: 75 Other: 82	F0000	Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit due to the scope and severity of all the citations being no higher than a "D" level. Please accept the following Plan of Correction as the facility's credible allegation of compliance. This Plan does not constitute an admission of guilt or liability by the facility. It is submitted only in response to the regulatory requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Total: 181 Sample: 8 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2 Quality review completed on August 15, 2011 by Bev Faulkner, RN			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure injuries of unknown origin were reported promptly to the Administrator and were thoroughly investigated for 2 of 3 residents reviewed	F0225	F225 Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit due to the scope and severity of all the citations being no higher than a “D” level.	09/02/2011

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	with bruises in a sample of 8. (Resident #C and Resident #G) Finding include: 1. Resident #C's record was reviewed on 8/10/11 at 1:25 p.m. Her diagnoses included, but were not limited to, osteoarthritis, falls, anxiety, and depression. A nursing note, dated 6/16/11 at 9:04 a.m., indicated Resident #C was observed by the CNA with a hematoma (bruise) to her forehead, a bruise to her right wrist and left forearm, and scratches and scab to her left lower leg. Neurological checks were implemented and an x-ray of the right wrist was ordered. The resident complained of pain to her forehead upon palpitation. The resident was alert and oriented with confusion. Review of the incident report provided by the Director of Nursing on 8/11/11 at 8:15 a.m., indicated Nursing Student #1's provided the following: "While providing care to (Resident #C's name) on 6/15/11, I noticed on her medial LLE (left lower extremity) 3 abrasions." Measurement of the abrasions were 2.0 cm (centimeters) by 1.5 cm for two of the abrasions and the third abrasion was 3 cm in width. "To her r (right) wrist I noticed a circular		Please accept the following Plan of Correction as the facility's credible allegation of compliance. This Plan does not constitute an admission of guilt or liability by the facility. It is submitted only in response to the regulatory requirements. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The corrective actions for residents listed are as follows: Resident G was interviewed at the time of occurrence and stated that the bruise was caused from shutting her wrist in a door. The bruise was monitored by nursing for changes. Bruise did not meet the criteria to report to ISDH per the facility policy. Injuries have resolved. Resident C was investigated once the bruise and hematoma was observed by a staff member. Her injuries have resolved. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. Current facility events were reviewed to ensure any current bruises have been investigated and the C.N.A. identified who was interviewed. Current bruises have been reviewed to determine if any meet the criteria to report to	

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	abrasion 1 cm in width. None of the above abrasions demonstrated any bleeding." I did not report there (sic) markings to anyone." The note was signed by Nursing Student #1 and the Nursing Student Instructor. Interview with the Director of Nursing on 8/11/11 at 9:25 a.m., indicated during the investigation of Resident #C's injuries it was determined Student Nurse #1 did see bruises on the resident on 6/15/11 and did not report the bruises to anyone. She further indicated the student nurses were inserviced on the abuse policy and reporting immediately. The student nurse was informed she should have told staff of the bruising she observed to a staff member.		ISDH and none were noted that have not already been reported. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff were re-inserviced by Director of Nursing/designee on the following: · New Skin tear/Bruise of Unknown Origin form. This form is completed for any un-witnessed skin tear or bruise. · How to investigate bruises/skin tears · What staff members to and how to interview · Report any changes in skin conditions to nursing immediately for observation and documentation · What qualifies as a reportable event to State When the next nursing student class begins, students will be educated on the above. Currently there are no student classes in the facility at this time. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The interdisciplinary team will review the investigation forms to ensure that the appropriate C.N.A.'s were interviewed and names of who was interviewed identified. The injury will be reviewed to determine if it qualifies as a reportable event to ISDH per facility policy and state regulations. A summary of the	

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			audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	
	2. Resident G's record was reviewed on 8/10/11 at 1:15 p.m. Resident G's diagnoses included, but were not limited to, hypertension, Alzheimer's disease, and anxiety. A resident progress note, dated 6/12/11 at 10:30 p.m., indicated "...At around 9 p.m., CNA was talking to resident at the nurses station when she noticed a bruise on resident's left wrist, she immediately notified writer who assessed the bruised wrist and noted that resident had three bruises on her left upper extremity. One was noted on resident's left medial (pertaining to midline) forearm proximal to her wrist. It was purple blue in color and measured 7 x (by) 5 cm (centimeters). On the medial wrist, writer observed a bluish bruise measuring 2.5 x 3 cm, and one on the lateral (pertaining to a side) wrist that is bluish red and measuring 3 x 3 cm. When asked how she got the bruises resident said, "I shut the door on			

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	my wrist yesterday." Writer asked resident five different times within a span of about an hour and half and got the same answer. Resident was noted to be able to move her wrist without a problem. She has been using it to wheel herself about the unit all day. When asked if she was in pain, resident replied, "No."...when writer touched the left lateral bruise, resident said, "that hurts when you touch it."...Writer paged (name of physician) and got a call from (another physician's name) who was on call...ordered an X-ray of the left wrist and also to monitor bruising to wrist Q (every) shift till resolved. Resident's daughter, (daughter's name), was called and notified...Writer also notified the DON (Director of Nursing)..." An Accident/Incident Investigation form, dated 6/12/11 at 9 p.m., indicated " Step 2: Interview the resident to determine what happened...BRUISES/SKIN TEARS: 1. Did you bump (name part of body) on anything? Yes "I shut the door on my wrist."...Step 3 Interview the C.N.A.: 1. When was the last time you saw the resident? 7:15 p.m. 2. What were they doing? By nursing station 3. When was the last time you toileted or provided incontinent care? 8:30 p.m. 4...was restraint/alarm in place and working? yes 5. Was resident having			

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	any behaviors prior to incident? no...9. Was call light in reach prior to you leaving the room? yes" At the top of the form, it indicated two CNA's were caring for the resident during this time. The form lacked documentation of which CNA had been interviewed. An Incident Summary form, dated 6/12/11 at 9 p.m., indicated the type of incident was unwitnessed, activity prior to the incident was unknown, the resident's mental status prior to incident was alert-disoriented, and the resident's mobility status prior to incident was assist/dependent. The Management Follow-Up To Incidents form (attached to the back of the incident form), indicated "Interview With Resident: How did you get the bruise? "I shut the door on my wrist yesterday" Did anybody hit or hurt you? "No," Interview With Staff: Sitting talking to resident noticed her wrist bruised reported it to the nurse. This form also lacked documentation of which CNA was interviewed and lacked any other interviews from the staff. A quarterly MDS (Minimum Data Set) assessment, dated 4/18/11, indicated a cognition score of "99," ,indicating the resident was unable to complete the			

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	interview. The staff assessment for mental status indicated short term and long term memory were unable to be assessed, and cognitive skills for daily decision making were moderately impaired. Social Services notes, on the following dates and times, indicated: 5/9/11 at 10:16 a.m., "...Resident was inattentive to writer during interview. When asked questions resident would stare at writer blankly and then look away. Per nursing she does have difficulty answering questions and her basic needs are anticipated by staff. Long term memory and short term memory is difficult to assess at this time due to resident's lack of answering questions. She is moderately impaired in decision making..." 5/13/11 at 12:25 p.m., "Resident did not participate in BIMS or MOOD as she would smile and rolled away from writer on 5/12/11. She just smiled when questions were being asked, so LTM (long term memory) and STM (short term memory) are difficult to evaluate at this time...She can make basic needs known and at times can follow simple demands..."			

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	5/27/11 at 1:09 p.m., "Resident did not participate in BIMS (measures cognition) or MOOD as she rolled away from writer on 5/27/11. She can be easily distracted. She smiled, then frowned when questions were being asked, so LTM and STM are difficult to evaluate at this time. Per staff...she is moderately impaired..." A care plan, updated 5/26/11, indicated "(Resident's name) exhibits short/long term memory deficits and impaired decision making." A care plan, updated 5/26/11, indicated "Resident under close observation due to cognitive deficits..." There was lack of documentation the bruise was reported to the Indiana State Department of Health. During an interview with the DoN, on 8/11/11 at 11:10 a.m., she indicated she understands more staff should have been interviewed due to the resident's cognition and the investigation should have been more thorough. She indicated bruises are only reported if over 8 centimeters. This Federal tag relates to complaint IN00093490. 3.1-28(c)			

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	3.1-28(d)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure the facility followed its abuse policy regarding reporting all allegations of abuse immediately to the Administrator and thoroughly investigating injuries of unknown origin for 2 of 3 residents reviewed with bruises in a sample of 8. (Resident #C and Resident #G) Finding include: 1. Resident #C's record was reviewed on 8/10/11 at 1:25 p.m. Her diagnoses included, but were not limited to, osteoarthritis, falls, anxiety, and depression.	F0226	**F226** Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit due to the scope and severity of all the citations being no higher than a “D” level. Please accept the following Plan of Correction as the facility’s credible allegation of compliance. This Plan does not constitute an admission of guilt or liability by the facility. It is submitted only in response to the regulatory requirements. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The corrective actions for resident listed are as follows: Resident G was interviewed at the time of	09/02/2011

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	A quarterly Minimum Data Set Assessment, dated 6/10/11, indicated the resident was usually understood and usually understands. Her long and short term memory could not be assessed. She was moderately impaired cognitively, indicating she made poor decisions and needed cueing and supervision. A significant change Minimum Data Set Assessment, dated 7/13/11, indicated she was usually understood and usually understands. She scored a 3 on her BIMS (Brief Interview of Mental Status) which indicated the resident had significant cognitive impairment. A nursing note, dated 6/16/11 at 9:04 a.m., indicated the resident was observed by the CNA with a hematoma (bruise) to her forehead, a bruise to her right wrist and left forearm, and scratches and scab to her left lower leg. Neurological checks were implemented and an x-ray of the right wrist was ordered. The resident complained of pain to her forehead upon palpitation. The resident was alert and oriented with confusion. Review of the incident report with investigation provided by the Director of Nursing on 8/11/11 at 8:15 a.m., indicated Nursing Student #1's provided the following: "While providing care to		occurrence and stated that the bruise was caused from shutting it in a door. The bruise was monitored by nursing for changes. Bruise did not meet the criteria to report to ISDH per the facility policy. Injuries have resolved. Resident C was investigated once the bruise and hematoma was observed by a staff member. Her injuries have resolved. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. Current facility events were reviewed to ensure any current bruises have been investigated and the C.N.A. identified who was interviewed. Current bruises have been reviewed to determine if any meet the criteria to report to ISDH and none were noted that have not already been reported. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff were re-inserviced by Director of Nursing/designee on the following: · New Skin tear/Bruise of Unknown Origin form. This form is completed for any un-witnessed skin tear or bruise. · How to investigate bruises/skin tears · What staff	

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	(Resident #C's name) on 6/15/11 I noticed on her medial LLE (left lower extremity) 3 abrasions." Measurement of the abrasions were 2.0 cm (centimeters) by 1.5 cm for two of the abrasions and the third abrasion was 3 cm in width. "To her r (right) wrist I noticed a circular abrasion 1 cm in width. Nome of the above abrasions demonstrated any bleeding." I did not report there (sic) markings to anyone." The note was signed by Nursing Student #1 and Nursing Student Instructor. The incident report indicated the incident occurred on 6/16/11 at 8:00 a.m. The resident reported she fell to the nurse. The resident was alert with confusion. Interview with the Director of Nursing on 8/11/11 at 9:25 a.m., indicated during the investigation of the Resident #C's injuries it was determined Student Nurse #1 did see bruises on the resident on 6/15/11 and did not report the bruises to anyone. She further indicated the student nurses were inserviced on the abuse policy and reporting immediately. The student nurse was informed she should have told staff of the bruising she observed to a staff member. 2. Resident G's record was reviewed on		members to and how to interview · Report any changes in skin conditions to nursing immediately for observation and documentation · What qualifies as a reportable event to State When the next nursing student class begins, students will be educated on the above. Currently there are no student classes in the facility at this time. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The interdisciplinary team will review the investigation forms to ensure that the appropriate C.N.A.'s were interviewed and names of who was interviewed identified. The injury will be reviewed to determine if it qualifies as a reportable event to ISDH per facility policy and state regulations. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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	8/10/11 at 1:15 p.m. Resident G's diagnoses included, but were not limited to, hypertension, Alzheimer's disease, and anxiety. A resident progress note, dated 6/12/11 at 10:30 p.m., indicated "...At around 9 p.m., CNA was talking to resident at the nurses station when she noticed a bruise on resident's left wrist, she immediately notified writer who assessed the bruised wrist and noted that resident had three bruises on her left upper extremity. One was noted on resident's left medial (pertaining to midline) forearm proximal to her wrist. It was purple blue in color and measured 7 x (by) 5 cm (centimeters). On the medial wrist, writer observed a bluish bruise measuring 2.5 x 3 cm, and one on the lateral (pertaining to a side) wrist that is bluish red and measuring 3 x 3 cm. When asked how she got the bruises resident said, "I shut the door on my wrist yesterday." Writer asked resident five different times within a span of about an hour and half and got the same answer. Resident was noted to be able to move her wrist without a problem. She has been using it to wheel herself about the unit all day. When asked if she was in pain , resident replied, "No."...when writer touched the left lateral bruise, resident said, "that hurts when you touch it."...Writer paged (name			

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	of physician) and got a call from (another physician's name) who was on call...ordered an X-ray of the left wrist and also to monitor bruising to wrist Q (every) shift till resolved. Resident's daughter, (daughter's name), was called and notified...Writer also notified the DON (Director of Nursing)...." An Accident/Incident Investigation form, dated 6/12/11 at 9 p.m., indicated " Step 2: Interview the resident to determine what happened...BRUISES/SKIN TEARS: 1. Did you bump (name part of body) on anything? Yes "I shut the door on my wrist."...Step 3 Interview the C.N.A.: 1. When was the last time you saw the resident? 7:15 p.m. 2. What were they doing? By nursing station 3. When was the last time you toileted or provided incontinent care? 8:30 p.m. 4...was restraint/alarm in place and working? yes 5. Was resident having any behaviors prior to incident? no...9. Was call light in reach prior to you leaving the room? yes" At the top of the form, it indicated two CNA's were caring for the resident during this time. The form lacked documentation of which CNA had been interviewed. An Incident Summary form, dated 6/12/11 at 9 p.m., indicated the type of incident was unwitnessed, activity prior to the			

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	incident was unknown, the resident's mental status prior to incident was alert-disoriented, and the resident's mobility status prior to incident was assist/dependent. The Management Follow-Up To Incidents form (attached to the back of the incident form), indicated "Interview With Resident: How did you get the bruise? "I shut the door on my wrist yesterday" Did anybody hit or hurt you? "No," Interview With Staff: Sitting talking to resident noticed her wrist bruised reported it to the nurse. This form also lacked documentation of which CNA was interviewed and lacked any other interviews from the staff. A quarterly MDS (Minimum Data Set) assessment, dated 4/18/11, indicated a cognition score of "99," indicating the resident was unable to complete the interview. The staff assessment for mental status indicated short term and long term memory were unable to be assessed, and cognitive skills for daily decision making were moderately impaired. Social Services notes, on the following dates and times, indicated: 5/9/11 at 10:16 a.m., "...Resident was			

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	inattentive to writer during interview. When asked questions resident would stare at writer blankly and then look away. Per nursing she does have difficulty answering questions and her basic needs are anticipated by staff. Long term memory and short term memory is difficult to assess at this time due to resident's lack of answering questions. She is moderately impaired in decision making..." 5/13/11 at 12:25 p.m., "Resident did not participate in BIMS or MOOD as she would smile and rolled away from writer on 5/12/11. She just smiled when questions were being asked, so LTM (long term memory) and STM (short term memory) are difficult to evaluate at this time...She can make basic needs known and at times can follow simple demands..." 5/27/11 at 1:09 p.m., "Resident did not participate in BIMS (measures cognition) or MOOD as she rolled away from writer on 5/27/11. She can be easily distracted. She smiled, then frowned when questions were being asked, so LTM and STM are difficult to evaluate at this time. Per staff...she is moderately impaired..." A care plan, updated 5/26/11, indicated "(Resident's name) exhibits short/long			

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	term memory deficits and impaired decision making." A care plan, updated 5/26/11, indicated "Resident under close observation due to cognitive deficits..." There was lack of documentation the bruise was reported to the Indiana State Department of Health. The Abuse Policy was provided by the Director of Nursing on 8/11/11 10:50 a.m. The policy statement: "All reports and/or allegations of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management. An injury of unknown source: "Injury of unknown source is defined as an injury that meets both of the following conditions: (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of: the extent of the injury; or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma; or the number of injuries observed at one particular point in time; or the incidence of injuries over time."			

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	The policy interpretation and implementation included, but was not limited to, the following: "should an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident." "The individual conducting the investigation will, as a minimum: a. Review the resident's medical record to determine event leading up to the incident; b. Interview the person(s) reporting the incident; c. Interview any witnesses to the incident; d. Interview the resident (as medically appropriate); e. Notify the resident's Attending Physician as needed. F. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; g. Interview the resident's roommate, family members, and visitors, when appropriate; h. Interview other residents to whom the accused employee provides care or services, and i. Review all events leading up to the alleged incident." During an interview with the Director of Nursing, on 8/11/11 at 11:10 a.m., she indicated she understands more staff should have been interviewed due to the			

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	resident's cognition and the investigation should have been more thorough. She indicated bruises are only reported if over 8 centimeters. This Federal tag relates to complaint IN00093490. 3.1-28(a)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a resident was transferred by two staff members and an assessment was completed after a fall for 1 of 3 residents reviewed for falls in a sample of 8. (Resident #C) Findings include: Resident #C's record was reviewed on 8/10/11 at 1:25 p.m. Her diagnoses included, but were not limited to, osteoarthritis, falls, anxiety, and depression.	F0323	F323 Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit due to the scope and severity of all the citations being no higher than a “D” level. Please accept the following Plan of Correction as the facility's credible allegation of compliance. This Plan does not constitute an admission of guilt or liability by the facility. It is submitted only in response to the regulatory requirements. **What corrective action(s) will be accomplished for those residents found to have been affected by the**	09/02/2011

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	A quarterly Minimum Data Set Assessment, dated 6/10/11, indicated the resident was usually understood and usually understands. Her long and short term memory could not be assessed. She was moderately impaired cognitively, indicating she made poor decisions and needed cueing and supervision. She was an extensive assist indicating resident involved in activity, staff provide weight-bearing support with a two plus person physical assist for transfers. A nursing note, dated 6/16/11 at 9:04 a.m., indicated the resident was observed by the CNA with a hematoma (bruise) to her forehead, a bruise to her right wrist and left forearm, and scratches and scab to her left lower leg. Neurological checks were implemented and an x-ray of the right wrist was ordered. The resident complained of pain to her forehead upon palpitation. The resident was alert and oriented with confusion. Review of the incident report with investigation provided by the Director of Nursing on 8/11/11 at 8:15 a.m., indicated the incident occurred on 6/16/11 at 8:00 a.m. The resident reported shell fell to the nurse. The resident was alert with confusion. A Management Follow-Up to Incidents		**deficient practice;** The corrective actions for resident listed are as follows: Resident C had a fall and body assessment completed immediately after the injuries were noted by a staff member. A thorough investigation was then completed by the interdisciplinary team to determine how the hematoma and fall occurred. Resident on 7/7/2011 was changed to a hoyer lift for transfer needs. She was not a hoyer lift at the time of the alleged fall. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. Residents were reviewed to determine current transfer needs and care cards updated if needed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff were re-inserviced by Director of Nursing/designee on the following: · Reporting all falls to nursing immediately for observation of injuries and documentation · Completing a body assessment after any fall · Completing the Fall assessment and event after any fall · Using two staff members with any	

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	form indicated "Resident stated yes when ask did she hit her head and did she fall." The Interdisciplinary Team Review: "6/16/11 Resident stated she fell when the CNA was transferring her this a.m. Assessed area to L (left) side of forehead 2.5 cm (centimeters) x (by) 2.5 cm, noted bruising to R (right) wrist, did ROM (range of motion) to wrist, resident had no c/o (complaints of) pain; neuro (neurological checks initiated, x-ray ordered. Staff interviews initiated. CNA #1's name suspended pending investigation." A Corrective Action Notice for CNA #1, dated 6/16/11 at 10:30 a.m., indicated a description of the problem: "(Resident #C's initials and room number) has hematoma (sic) 2.5 x (by) 2.5 to L (left) side of forehead light purple in color and bruising to bilateral wrists, res. (resident) states she fell-hematoma noted and reported at 7:50 a.m. What must be done to correct the situation: "Check res. [resident] [run] [sic] (started care on her residents) when you come in and report anything unusual to the appropriate people-CNA inserviced on the above." Employee comment: "I did not bruise or hurt (Resident's #C's name). I found her that way when I got her out of the bed." The facility's Evaluating Falls and Their		mechanical lift · Reviewing the care card to determine transfer needs **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** When a fall occurs during a transfer the interdisciplinary team will investigate if the proper transfer needs were used such as correct number of staff members, use of a mechanical lift, gait belt, etc. The interdisciplinary team will ensure that a fall and body assessment are completed with any fall. Staff members will be disciplined if any non-compliance was found for an improper transfer. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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	Cause Policy was provided by the Director of Nursing (DoN) on 8/11/11 at 2:00 p.m. The steps to take after a fall included, but was not limited to, "If a resident has just fallen, or is observed on the floor without a witness to the event, nursing staff will record vital signs and evaluate for possible injuries to the head, neck, spine and extremities." A professional resource, titled, "Indiana State Department of Health Division of Long Term Care Nurse Aide Training Program July 1998", Topic 22: Transferring, indicated, "...4. A mechanical lift...have at least one co-worker assist when using a mechanical lift..." A professional resource, titled, "Indiana State Department of Health Division of Long term Care Nurse Aide Training Program July 1998", Topic 8: Emergencies, indicated, "...b. Falls...1) Call for help immediately. Keep the resident in the same position until the nurse examines the resident..." Interview with the Director of Nursing on 8/11/11 at 9:25 a.m., indicated during the investigation of the Resident #C's injuries the resident indicated she fell during a transfer. She further indicated the resident described CNA #1 as the staff			

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	member who transferred her during the fall. The DoN also indicated the CNA #1 transferred her by herself and no assessment was completed prior to moving the resident. The DoN further indicated CNA #1 had not checked her residents when she started her shift as she had been trained. She just started her run (getting her residents up). Interview with the Director of Nursing on 8/11/11 at 2:00 p.m., indicated the issues with the incident regarding Resident #C was the resident should have been transferred with two persons and transfer was only completed with one person, as well as, the resident fell and no assessment was completed prior to moving the resident. There was no issue with the mechanism used to transfer the resident. Interview with the Director of Nursing on 8/11/11 at 2:35 p.m., indicated Resident #C was to by transferred by the Hoyer lift with two staff members present during the transfer per the resident's care card. This Federal tag relates to complaint IN00093490. 3.1-45(a)(2)			

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure resident records were complete for 1 of 8 residents reviewed related to documenting oral care and meal consumption for 1 resident in a sample of 8. (Resident #D) Findings include: The record for Resident #D was reviewed on 8/10/11 at 2:45 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease, osteoarthritis, hypertension and depressive disorder. Review of the computerized food consumption record indicated no entries	F0514	F514 Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit due to the scope and severity of all the citations being no higher than a “D” level. Please accept the following Plan of Correction as the facility’s credible allegation of compliance. This Plan does not constitute an admission of guilt or liability by the facility. It is submitted only in response to the regulatory requirements. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The corrective actions for resident listed are as follows: Resident D had no negative effects from the missing entries on the food and	09/02/2011

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	for the resident's food consumption for breakfast and lunch on 8/2/11 and 8/5/11 and no entries for dinner on 8/10/11. Review of the Restorative Feeding Program: Daily Record for August 2011, indicated no entries had been made for breakfast and lunch on 8/2/11. On 8/5/11, for breakfast and lunch the word "Room" was written. There was no entry for dinner on 8/10/11. Review of the Point of Care History for "How did the resident maintain personal hygiene" from 7/1/11 to 8/11/11, indicated personal hygiene was completed on time on the following day: 7/1, 7/2, 7/4. 7/6, 7/7, 7/8, 7/9, 7/10, 7/11, 7/14, 7/16, 7/17, 7/18, 7/20, 7/25, 7/26, 7/30, 7/31, 8/2, 8/4, 8/8, 8/9, and 8/10/11. There were no entries on the following days: 7/5, 7/21, 7/28, 7/29, 8/1, and 8/3/11. An interview with the Director of Nursing (DoN) on 8/11/11 at 10:25 a.m., indicated oral care was provided to the residents twice a day. She further indicated the care would be provided in the morning and the evening. She then indicated she, facility managers and the Assistant Administrator make rounds to ensure grooming, bathing and nail care had been completed for the residents.		oral documentation section. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff were re-inserviced by Director of Nursing/designee on the following: · Completing the food consumption sections in Matrix (Matrix is the electronic medical record system used for resident charting) to identify what the resident ate at each meal · Completing the oral care section in Matrix to identify that hygiene was provided to the resident. · Completing the paper version or the food and/or oral care sheet if they did not document in Matrix **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The nurse/designee will audit the Matrix to determine if the C.N.A. did not document on the food consumption and/or oral care section. If the C.N.A. did not document in Matrix, the nurse/designee will alert the C.N.A. and they will be required	

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	Interview with the Restorative nurse on 8/11/11 at 2:00 p.m., indicated oral care would be documented on the Point of Care History under "How did the resident maintain personal hygiene" sections. Interview with the DoN on 8/11/11 at 2:10 p.m., indicated there was no document for Resident #D for breakfast and dinner on 8/2/11 and 8/5/11 or dinner on 8/10/11 and the meal consumption should have been documented. She indicated he had his meals. This Federal tag relates to complaint IN00094635. 3.1-50(a)(1)		to complete the paper version of the missing section. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	